Rehabilitative Services: Occupational Therapy Authorization Form

Please fax the completed form to the plan listed below:

- Tufts Health Plan Commercial Plans; Fax: 617.972.9409
- Tufts Health Freedom Plan products; Fax: 617.972.9409
- Tufts Health Direct – Health Connector; Fax: 888.415.9055

1. Member name:	2. DOB:	3. DOI:	4. Date of report:	
5. Member ID#:	6. ICD-10:		7. Diagnosis:	
8. Facility name:	9. Tufts Health Plan Facility ID #:		10. Facility phone #:	11. Facility fax:
12. Previous Rx for this Dx? Yes ☐ No ☐	13. Any other Dx? Yes ☐ No ☐		14. Total visits since start of care:	15. # of visits requested:
16. Start of Care:		17. Estimated Discharge Date:		

18. Initial/Previous Clinical Status	**19. Current Clinical Status**	**20. Current Functional Status**
A. Pain Intensity: 0/10-10/10: B. ROM: C. Strength: D. Alignment: E. Ambulatory Status/Balance: F. Sensory/Reflexes:	A. Pain Intensity: 0/10-10/10: B. ROM: C. Strength: D. Alignment: E. Ambulatory Status/Balance: F. Sensory/Reflexes:	Please use this scale for 1-4: (1: Fully Able 75-100%, 2: 50-75%, 3: 25-50%, 4: 0-25%) A. Personal Care: 1☐ 2☐ 3☐ 4 ☐ N/A ☐ B. Household Mobility: 1☐ 2☐ 3☐ 4 ☐ N/A ☐ C. Community Mobility: 1☐ 2☐ 3☐ 4 ☐ N/A ☐ D. Sitting Tolerance: 1☐ 2☐ 3☐ 4 ☐ N/A ☐ E. Stair Climbing: 1☐ 2☐ 3☐ 4 ☐ N/A ☐ F. Driving: 1☐ 2☐ 3☐ 4 ☐ N/A ☐ G. Household Chores: 1☐ 2☐ 3☐ 4 ☐ N/A ☐ H. Lift Objects 1-10 lbs.: 1☐ 2☐ 3☐ 4 ☐ N/A ☐ I. Lift Objects >20 lbs.: 1☐ 2☐ 3☐ 4 ☐ N/A ☐ J. Work Tolerance: 1☐ 2☐ 3☐ 4 ☐ N/A ☐ K. Sports/Recreation: 1☐ 2☐ 3☐ 4 ☐ N/A ☐
Comments:		

21. Current Treatment Plan:	22. Current Clinical Goals:	23. Functional Outcomes:

Provider name: Requested by:	Provider #: Electronic Signature:

Provider Services